

			PATIEN	T INFORMA	ATION			
Name:			_,				Male	☐ Female
Address:	Last			First		M. I.		
Home Phone: ()	Street	Busin	ess Phone: (	City )		State Cell Phone: () _	Z	ip 
Date of Birth:		Ma	arital Status:	Single	☐ Marrie	ed Divorced	□ Wi	idowed
SS #:		E-Mail:						
Driver's License Number:		Physic	ian you are h	nere to see				
Referred By:				Have you c	or any family mer	mber been seen here b	efore? 🗌 Y	′es □ No
Preferred Pharmacy		Address _				Phone _		
	GUARANT	OR INFORM	ATION -	Must be comple	eted (Patient and	d/or Responsible Party)		
Responsible Party Name							_	☐ Female
Date of Birth:	Last Day / Year	Drive	er's License #	First :		M. I. Social Sec. #:		
Employer Name:						Employer Phone: (	_)	
Employer Address:						Occupation:		
		PRIM	IARY INSU	JRANCE IN	FORMATION			
Insurance Company Name							☐ PPO	☐ Private
Name of Insured								
Address	Last			0''	First			M. I.
Date of Birth (Insured)			D ()/	City		State	⁄lale □Fer	<sup>Zip</sup> male
Social Security Number:			Day / Year Insurar	nce ID #:				
Group Number:		Employer:				Occup	oation:	
Relationship to Patient:	☐ Self	□ Parent	☐ Spouse	e 🗌 Other: _				
		SECO	NDARY IN	SURANCE I	NFORMATIC	N		
Insurance Company Name							☐ PPO	☐ Private
Name of Insured	Last				First			
Address				0''	First			M. I.
Date of Birth (Insured)	Street	Month /	Day / Vaar	City		State Male	□Fer	<sup>Zip</sup> male
Social Security Number:			Day / Year Insur	rance ID #:				
Group Number:		Employer:				Occup	oation:	
Relationship to Patient:	☐ Self	□ Parent	☐ Spouse	e 🗌 Other: _				
		EMER	RGENCY C	ONTACT IN	IFORMATION	N		
Name of Person to Contact:					Relationsh	ip		
Address	Street			Other		Otata		7:
Home Phone ()				City Work F	Phone ()	State		Zip
I hereby assign my insurance insurance information is accuresponsible for all charges th understand that any initial dwill be charged a 1% finance carriers upon request for the gagreement shall be as valid cannot render services on the company. If we have problem acknowledge that I have read	rate and that I at are not cover letermination of echarge on all ourpose of payr as the original. It is assumption that collecting particular as collecting particular are col	am an eligible not am an eligible not am ared by my insurfactions of my co-payment for medica Payment is dout charges byment from you	nember and urance comparent (from my 90 days. I all services and ue at the time will be paid by u, we will also	Inderstand that I hy. Co-payment card or online) also hereby auth I further treatme e services are r the Insurance ( add attorney's f	am responsible for the amounts are sure is subject to final corrigation to for the release of the care by another endered. All characters, collection agrees, collection agrees, collection agrees.	for knowing my benefits/ ubject to final adjudicatal verification by my heat of all information to other physician. I further aurges are the direct respence is an agreement bet gency costs and any relations.	coverage. I with the coverage is a like the c	rill be financially alth plan and I nderstand that I and insurance notocopy of this patient. We your insurance
acknowledge that I have read							ited fees to yo	ur bill. I hereb
Patient's Signature:						Date:		



## **Permission to Relay Information**

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled

	Will be Harialea.
, give my permission for Comprehensive Care Center of Irvine ormation related to my personal health, as indicated below. This	
	request supersedes any prior request for comm
	Phone
one. YES NO NO	Contact me regarding my test results by telepho
oice mail. YES NO NO	Leave messages on my answering machine/vo
:	You may use the following telephone numbers:
	Work
· · · · · · · · · · · · · · · · · · ·	Home
	Cell Phone
al information with the following people (Print Names):	You may leave messages regarding my medica
2	1
4	3
ay Health / NextMD) YES \( \Boxed{\omega} \) NO \( \Boxed{\omega}	<b>E-Mail</b> Send e-mail messages by secured e-mail (Rela
, my condition and treatment YES \( \square \) NO \( \square \)	<b>Mail</b> Send mail regarding appointments, test results
<del></del>	Address:
Date: Date of Birth: ent or Legal Guardian must sign.)	Signature:(Patient signature, if Patient is a minor then Pare
	Nama
al information with the following people (Print Names):  2	You may use the following telephone numbers:  Work

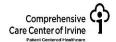
## **Acknowledgement of Receipt of Notice of Privacy Practices**



## 250 East Yale Loop, Suite 204, Irvine, CA 92604

Privacy Officer: Kristina Leatherman, Manager (949)732-3530 Effective Date: April 18, 2011 I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment. Print Name: \_\_\_\_ Telephone: If not signed by the patient, please indicate: Relationship: ☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient ☐ Beneficiary or personal representative of deceased patient Name of Patient: **Notice of Privacy Practices Acknowledgment Tracking Information** Complete the following only if the Patient refuses to sign the Acknowledgment: Efforts to obtain: Reasons for refusal:

Employee Name:



Name:		Date:					
Birthdate:		Previous Primary Physician:					
		Current Specialists:					
<b>A.</b> 11 (1							
Medications	ronth, taka ragularh,	(including non properintion)					
Please list any medications with strength that you cur	rently take regularly	(including non-prescription)					
<del></del>		<del></del>					
		<del></del>					
		<del></del>					
Allergies							
Please list any allergies to medications, foods or othe	r						
Ticase list arry allergies to medications, loods of othe							
<u>Medication</u>	Food	Oi.	ther				
			<del></del>				
<del></del> -		<del></del>	<del></del>				
<del></del> -		<del></del>	<del></del>				
Medical History							
Illnesses/Conditions		Surgical Procedures/Hospitalizations	Year				
Do you have or have you ever had any of the followin	g:						
	Year						
Anemia			<u></u>				
Anethesia complications	·						
Anxiety	·						
Arthritis							
Asthma		Childhood Diseases	Year				
Birth Defects		Chickenpox					
Cancer (type:	)	Measles	<del></del>				
Colitis	<u>'</u>	Mumps					
Concussion		Polio	<del></del>				
Depression/Nervous Breakdown		Other:					
Diabetes							
Emphysema							
Heart Attack/Heart Disease		Gynecological History (women only)					
High Blood Pressure		Last menstrual period					
High Cholesterol		How many pregnancies have you had?					
Kidney Disease		How many children do you have?	<del></del>				
Liver Disease/Hepatitis		Have you ever had an abnormal pap?	<del></del>				
Migraine Headaches		Have you had a hysterectomy?					
Mitral Valve Prolapse/Murmur	-	Have your ovaries been removed?	<del></del>				
Osteoporosis		riave your ovalies been removed:					
Pneumonia							
Rheumatic Fever	-						
Seizure Disorder							
Sexually Transmitted Disease	<del></del>						
Stroke	<del></del>						
Thyroid Disorder							
Tuberculosis							
Ulcer							
Health Maintenance							
When, if ever, did you last have any of the following:		List Year of Last Vaccinations:					
which, if ever, did you last have any of the following.		LIST TEAT OF LAST VACCITIATIONS.					
Cholesterol check Pap Sm	near	Tetanus (TD)	Hepatitis A				
		TB Skin Test	Hepatitis B				
	stress test						
		Pneumonia	Shingles (Zostavax)				
Mammogram Bone De	ટાાગાપુ						

Name:



Health Maintenance continued

			Birthda		
Family History					_
Has any blood relative ever	had any of the following : Relative (mother, father,	sister children)		Living Age	Deceased Age (at death) & cause
Alcoholism	Relative (Illottiel, latilel,	sister, crilidren)	Father	Age	Age (at death) & cause
Asthma	-		Mother	-	
Bleeding problems			Brother		
Cancer					
Type:				-	
Diabetes			Sister	-	
Emphysema	-				
Glaucoma					
Heart Attack			Son		
Heart Disease					
High Blood Pressure					
Mental Illness / Suicide			Daughter		
Osteoporosis					
Seizures					
Stroke			Husband/W	ife	
Thyroid					
Social History					
·	O'conta Adamsia d	D'	147.1		Destroye
Marital Status?	Single Married		Widow		Partner
Do you have children / depe	endents at nome?		w many?	<del></del>	
Are you employed?			upation?		Ovit data?
Do you or have you ever sm		? Yes/N	o When?		Quit date?
Do you or have you ever use	r day/ yrs	Yes / No	Type? Type?		How often? How often?
Do you drink alcohol?	eu illegal urugs :	Yes / No	Type? Type?		How often?
Have you been exposed to t	tovic substances?	Yes / No	Type:	′	low onem:
Do you drink caffeine daily?	loxic substances:	Yes / No	Type?	ı	How often?
Do you exercise regularly?		Yes / No	Type?		How often?
Do you wear seat belts?		Yes / No	турс:		TOW OILCIT:
Do you have a living will or a	advance directives?	Yes / No			
What is your highest level of		1637140			
, ,				<del></del>	
Review of Symptoms Please check any of the follo	owing that you are experie	encing:			
General	Fatigue Fever Recent Weight Loss / Ga		ot Flashes Insor est in Usual Activities	nnia N	ight Sweats Poor Concentration
Skin	Change in Pigmentation	Eczema H	ives Jaundice	Rashes	
ENT	Change in Vision / Heari Hearing Loss Neck	ing Dizziness Stiffness Nose E	Enlarged Glands Bleeds Chronic S	Glaucon inus or Ear	
Respiratory	Asthma Difficulty Bound	reathing Frequer	t Colds / Coughing	Shortnes	ss of Breath
Cardiac	Angina Chest Pain Palpitations Swellin	Difficulty Walkinզ ig of Hands / Feet	g 2 Blocks Heart	Murmur	High Blood Pressure
Gastrointestinal	Abdominal Pain / Cramp Frequent Indigestion / H	O .	0	n Bowel Ha Hemorrho	·
Genitourinary	Difficulty Urinating	Frequent Urination	Loss of Bladder Co	ntrol U	Insatisfactory Sex Life
Musculoskeletal	Joint Pain or Swelling	Difficulty Walking	Muscle Cramping	ı or Weakne	ess Varicose Veins
Neuropsychiatric	Prior Treatment for Depr	ression / Psychiatric C	are Fainting Spe	ells Par	ralysis Convulsions
Hematologic	Easy Bruising Exce	essive Bleeding After (	Cuts Slow Healin	g After Cuts	5



## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and reports. Note: Information and records regarding minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.

I here	by authorize: Name:							
	Address:							
	City/State/Zip:							
	Phone:		Fax:					
treatn		rognosis, incl	uding x-ra			onsultation, prescriptions, or medical records by		
То:	[ ] Dr. Kalena I [ ] Dr. Amanda [ ] Dr. Andrew [ ] Sarah Camp	Binns Siskind	At:	250 Eas Irvine,	ehensive Care Co st Yale Loop, Su CA 92604 )732-3530	enter of Irvine, Inc. ite 204 F: (949)999-8160		
	nedical information Change of Primary							
[ ] U <sub>1</sub> [ ] Li This a	[ ] Test Results [ ] Immunization [ ] Other: authorization shall lession for further us	g medical infor f records (progr s be effective in e or disclosur	rmation: ress notes, nmediatel e of this 1	y and ren	nain in effect un	til t granted unless another		
author by lav		from me or u	nless suc	h disclos	ure is specifically	y required or permitted		
_	otocopy or facsimile al. I have been adv					ective and valid as the zation.		
Signat	ure of Patient, Guard	ian / Legal Rep	resentativ	e	Relationship (if o	other than Patient)		
Patien	t's Name (PRINT)			_	Date of Request			
Patien	t's Social Security N	umber		_	Patient's Date of	Birth		
Witnes	SS			_	Date Records Ser	nt		